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Case Report

Premature Treatment Termination by Angry Patients with Combat-Related Post-Traumatic Stress Disorder

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Angry patients with conjoined post-traumatic stress disorder often direct their anger at health care providers during the course of treatment. Such misplaced anger can interfere with treatment. Emerging treatments for trauma-related anger are effective. However, even in the course of psychotherapy for trauma-related anger, these patients direct anger at their therapists, compromising the treatment alliance and increasing the likelihood of premature termination. A case example is presented to illustrate the effect of anger on the treatment alliance. A therapeutic strategy is proposed to reduce the likelihood of premature treatment termination in these high-risk patients. This strategy may also be helpful in primary care contexts.

Introduction

Patients with post-traumatic stress disorder (PTSD) have higher rates of medical complaints, diagnosed medical conditions, and clinical service utilization than patients without PTSD.[1] In a recent study of PTSD in primary care, Samson et al.[2] found that 38.6% of patients who met Diagnostic and Statistical Manual of Mental Disorder, Fourth Edition, diagnostic criteria for PTSD were frequent users of medical services 12 months before diagnosis. The most frequent traumas associated with PTSD in this sample were adult domestic violence and child abuse. The majority of these patients sought treatment in primary care settings rather than mental health settings.

Patients with combat-related PTSD are often difficult to maintain in treatment.[3] This problem is further complicated by the high prevalence of severe anger among combat veterans diagnosed with PTSD.[4,5] The anger experienced by patients with combat-related PTSD tends to result in treatment avoidance, interferes with the initiation and maintenance of treatment, and often leads to premature treatment termination.

Moreover, the trauma-related anger experienced by these patients tends to be recapitulated in their relationships with their therapists. This anger creates a difficult treatment environment[6] and impedes the development of an effective therapeutic alliance. This anger is often indiscriminately directed at those who would seek to provide treatment, including both mental health and primary care providers. We describe a case of premature termination of treatment by a patient with conjoined combat-related PTSD and extreme anger. A conceptual framework for understanding premature termination is then presented, followed by preliminary clinical recommendations to reduce the likelihood of premature treatment termination. Suggestions for the use of this approach in primary care settings are presented.

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Case Report

Background History

Mr. A is a 30-year-old Gulf War-era veteran. He grew up in a rural community, with two siblings. His family was very poor; he remembered searching through garbage cans for food. Mr. A reported that his father, a Vietnam combat veteran, regularly beat him. Although injuries from these beatings warranted medical attention, they were never treated. Despite this history of physical abuse, Mr. A denied experiencing significant psychological or medical problems before military enlistment. He denied alcohol dependence or abuse.

Military History

Mr. A served as an enlisted Marine rifleman. Beginning with military training, he noticed cognitive and emotional changes in himself. Physical aggression by military instructors was commonplace, and he felt increasingly hostile toward the other trainees. During service, he killed an enemy soldier in a firefight. He vividly remembered subsequently feeling estranged from himself and others. Mr. A later killed several other enemy soldiers in the same conflict, and he lost friends in combat. He also reported being haunted by his memories of being injured by a mortar explosion. He remembers thinking that he was dead or paralyzed as he lay on the ground. Mr. A's military service was otherwise undistinguished.

Post-Military Adjustment

Mr. A joined a law enforcement agency after military discharge. His propensity to use excessive force with suspects soon became a problem. Mr. A reported very low threat tolerance, responding with anger and aggression whenever threatened. He soon acquired a reputation for seriously injuring suspects who resisted arrest. He reported that his aggression was reflexive and automatic: "I couldn't hold myself back." His aggressive reactions were characterized by a disproportionate "all-or-none" quality. One suspect, who only mildly resisted him, suffered fractured bones.

In another incident, while driving home from work, Mr. A recognized a man that he had reprimanded for shoplifting a few

days earlier. The man had threatened to harm Mr. A's family, in response to which Mr. A had threatened to break the man's kneecaps if he ever saw him in his neighborhood. Mr. A reported that his only thought was of "breaking his kneecaps so that he could not harm my family." Mr. A stopped the car and, using a blackjack and flashlight, broke the man's kneecaps. Mr. A described this response as automatic and stated, "I could not take any chances; I did not know what he was going to do." On inquiry, Mr. A reported that he perceived his family to be in direct danger and was only ensuring their safety. Even other law enforcement officers were careful not to intervene when he became aggressive, having witnessed his explosiveness. In an incident that cost him his job, Mr. A reacted to a man whose physical characteristics reminded him of the enemy he had encountered in combat. He perceived the man's resistant behavior as an imminent threat. He beat the man and recalled wanting to "kill him." He choked the man as fellow officers around him shouted, "Stop, please stop, you are going to kill him." Despite this, he could not stop himself. Mr. A later reported feeling as if he was in "combat" again.

At home, he was reported to have broken appliances and destroyed furniture during episodes of rage. He denied being physically aggressive with his wife or children. His children feared him, as reflected in his son's pleading during discipline, "Daddy, please take your medicine."

Seeking Treatment

A few years after military discharge, Mr. A began having nightmares of his deceased friends and of his near-death experience during the mortar explosion. Mrs. A reported several apparent dissociative episodes during which Mr. A would leave their bedroom, returning with muddy feet. Mr. A does not recall any of these episodes. When Mr. A reported nightmares and severe anger problems, his family physician recommended that he seek help from the Veterans Administration (VA). This led to a diagnosis of PTSD and intermittent explosive disorder.

The Challenge of Establishing a Therapeutic Alliance

Mr. A presented for treatment highly motivated to control his anger. However, several anger-related issues impeded the development of a therapeutic alliance. For example, despite an explanation of the importance of learning relaxation and other arousal-reduction techniques as part of the treatment of severe anger, he refused to participate. In addition, efforts to encourage home practice of relaxation were unsuccessful. During discussion of barriers to his learning relaxation methods, he maintained that he "had no time to practice." On further inquiry, he admitted that anger made him feel powerful and in control, whereas relaxation made him feel "vulnerable." During treatment sessions, Mr. A seemed more interested in discussing how he had beaten someone than in better understanding his anger, as if attempting to emphasize his power in the therapy. It appeared difficult for him to "relax his guard" even in treatment. Indeed, Mr. A made it clear in his first session that he did not trust anyone, including his wife.

Although he never threatened his therapist overtly, anger toward a VA employee resulted in indirect anger toward the therapist. Mr. A reported being angry at the therapist because he was a part of the "VA system." Distinguishing his relationship with the therapist from his relationship with other treatment staff was difficult for Mr. A. Therapist-specific anger was exacerbated by an incident during which another veteran with PTSD was denied VA services. Mr. A reported, "You all kicked a wounded veteran off the chopper." Mr. A's perception that the VA was the enemy was extended to include his therapist, who could no longer be trusted. Mr. A abruptly terminated therapy and angrily refused further contact.

Discussion

The difficulty of retaining patients with conjoined PTSD and severe anger in treatment is primarily related to the challenge of maintaining a therapeutic alliance in the face of reflexive anger. Thus, these patients often terminate therapy prematurely when the primary care provider or therapist becomes a target of their anger. This anger may erupt during direct interaction with the health care provider or generalize through associating the health care provider with some other person or organization perceived as threatening. In view of the significant social and interpersonal costs of anger and aggression, it is important to understand premature termination of anger treatment to maximize treatment retention and effectiveness.

Chemtob and colleagues[7] have proposed that severe anger in PTSD is facilitated as part of the activation of a "survival mode" of functioning, which is defined as the automatic activation of cognitive structures and behaviors especially adapted for responding to life threats. Survival mode functioning is triggered by perceived threat, is preemptive of normal cognitive processing, is characterized by threat confirmation biases, and is defined by response automaticity and loss of self-monitoring.[8] Although it is adaptive in actual life-threatening situations (e.g., combat), the survival mode is maladaptive in civilian contexts (e.g., social events).

The prolonged and repetitive activation of the survival mode in actual life-threatening situations such as combat may alter threat assessment in non-life-threatening situations, facilitating anger and aggression. Thus, patients with PTSD and severe anger may be resistant to giving up anger and aggression because these characteristics served an essential role in their survival. Mr. A reported feeling powerful and in control when he became angry, and he was concerned that relaxation would make him dangerously vulnerable.

The activation of the survival mode increases the probability that the primary care doctor or therapist will be perceived as a threat. If the therapist is perceived as a threat or enemy, the chances increase that he or she may become a target of the patient's anger. Also, the patient may perceive the specific anger treatment (e.g., relaxation) itself as an attempt to weaken him. In summary, we propose that the angry patient recapitulates his or her relationship to the original threatening environment, for which the therapist or primary care doctor becomes a substitute. This necessarily compromises treatment engagement, an important predictor of PTSD therapeutic outcome.[9]

Santisteban et al.[10] demonstrated that systematically addressing the issues that prevent treatment engagement as part of the initiation of treatment increased therapeutic engagement and significantly improved retention. Given that anger toward the therapist is expected to have negative effects on treatment engagement and alliance, these findings suggest that anticipat-

ing as part of PTSD treatment initiation that anger will be directed toward the therapist will help to maintain engagement and prevent premature termination.

Although there is a paucity of research on premature termination and on the means of increasing retention, inclusion of family members in treatment has been associated with increased retention.[11] This is true even when family members are included only in the treatment engagement phase. In their review of studies of retention in adult drug abuse treatment, Stanton and Shadish[11] noted that studies involving a family therapy condition had an average retention rate of 66%, compared with individual treatment retention rates ranging from 5% to 36%. This seems to suggest the potential of preventing premature treatment termination by including the significant others of patients with PTSD and severe anger in the treatment engagement process.

Given the further risk to cardiovascular functioning of high anger, we strongly recommend that medical providers refer patients with conjoined anger and trauma for anger treatment. However, such referral may itself cause anger in the patient. To facilitate the process of referral, we recommend that primary care providers normalize the anger by noting that (a) it is a risk factor for physical health, (b) trauma and high anger are usually associated, and (c) anger can become directed at those who would seek to help. This will help the patient regulate his or her anger and will likely increase the chance that the patient will follow though with the referral.

In addition, we propose that psychotherapists who deal with patients with conjoined high anger and PTSD consider initiating treatment by investing significant treatment time preparing both the patient and family members (particularly spouses) for the likelihood that anger will be directed at the therapist and may lead to premature termination of treatment. Once such anger arises, it will then seem less personal and less therapist specific, because it will have been described as an expected and normal part of the course of treatment. Moreover, including the spouse in the effort to help the patient anticipate trauma-related anger directed at the therapist increases the likelihood of healthy "triangulation," in which both therapist and spouse ally to offset the patient's anger-related treatment avoidance. A treatment trial evaluating these proposed treatment modifications is currently under way in our laboratory.

References

1. Friedman MJ, Schnurr P: Trauma, PTSD, and health. National Center for PTSD Clinical Quarterly 1996; 6(4): 75–6.
2. Samson AY, Bensen S, Beck A, Price D, Nimmer C: Posttraumatic stress disorder in primary care. J Fam Pract 1999; 48: 222–7.
3. Solomon SD, Gerrity ET, Muff AM: Efficacy of treatments for posttraumatic stress disorder. JAMA 1992; 268: 633–8.
4. Chemtob CM, Hamada RS, Roitblat HL, Muraoka MY: Anger, impulsivity, and anger control in combat-related posttraumatic stress disorder. J Consult Clin Psychol 1994; 62: 827–32.
5. Lasko NB, Gurvits TV, Kuhne AA, Orr SP, Pitman RK: Aggression and its correlates in Vietnam veterans with and without chronic posttraumatic stress disorder. Compr Psychiatry 1994; 35: 373–81.
6. Novaco RW, Chemtob CM: Anger and trauma: conceptualization, assessment, and treatment. In Cognitive-Behavioral Therapies for Trauma, pp 162–90. Edited by Follette VM, Ruzek JL, Abueg F. New York, Guilford Press, 1998.
7. Chemtob CM, Novaco RW, Hamada RS, Gross DM, Smith G: Anger regulation deficits in combat-related posttraumatic stress disorder. J Trauma Stress 1997; 10: 17–36.
8. Chemtob CM, Roitblat HL, Hamada RS, Carlson JG, Twentyman CT: A cognitive action theory of post-traumatic stress disorder. J Anxiety Disord 1988; 2: 253–75.
9. Foa EB, Riggs DS, Massie ED, Yarczower M: The impact of fear activation and anger on the efficacy of exposure treatment for posttraumatic stress disorder. Behav Ther 1995; 26: 487–99.
10. Santisteban DA, Szapocznik J, Perez-Vidal A, Kurtines WM, Murray EJ, LaPerriere A: Efficacy of intervention for engaging youth and families into treatment and some variables that may contribute to differential effectiveness. J Fam Psychol 1996; 10: 35–44.
11. Stanton MD, Shadish WR: Outcome, attrition, and family-couples treatment for drug abuse: a meta-analysis and review of the controlled, comparative studies. Psychol Bull 1997; 122: 170–91.